PERSONAL HEALTH RECORD of (name) _____ **Age:** _____ **Date Record Updated:** _____

Address: _____

Phone#: _____ **E-Mail:** _____ **Primary Language Spoken:** _____

Emergency Contact:

Name: _____

Phone#: _____

Relationship: ☐ Wife ☐ Son ☐ Husband ☐ Partner ☐ Daughter ☐ Other

Health Care Proxy 1:

Name: _____

Phone#: _____

Relationship: _____

Health Care Proxy 2:

Name: _____

Phone#: _____

Relationship: _____

Primary Doctor:

Name: _____

Phone#: _____

Date Last Seen: _____

Specialist Doctor:

Name: _____

Phone#: _____

Date Last Seen: _____

Reason: _____

Other Doctor:

Name: _____

Phone#: _____

Date Last Seen: _____

Reason: _____

ALLERGIES:

☐ **NONE**

☐ Latex

☐ Bandaid Adhesive

☐ Medicine **(name)**

_____

_____

☐ Food **(name)**

_____

_____

☐ Insect **(name)**

_____

☐ Other **(name)**

_____

_____

_____

HEALTH PROBLEMS:

☐ **NONE**

☐ Arthritis

☐ Asthma

☐ Bleeding Problem

☐ Breathing Difficulty

☐ COPD

☐ Cancer **(where)** _____

☐ Depression

☐ Diabetes (sugar in the blood)

☐ Heart Problems

☐ Hearing Problems

☐ High Blood Pressure

☐ High Cholesterol

☐ Osteoporosis

☐ Seizures

☐ Thyroid Problem

☐ Other _____

MEDICATIONS:

(Prescription, over the counter & Herbal)

Include Dose/Amount

(mg. Number of pill)/(# pills each day)

☐ **NONE**

HOSPITAL STAYS:

☐ **NONE**

Screening Tests (DATE)

Mammogram _____

PAP Smear _____

Prostate _____

Colonoscopy _____

Vaccines: (DATE)

Flu _____

Pneumonia _____

Tetanus _____

Diptheria _____

Do you have any problem with?

☐ **NONE**

Seeing _____

Hearing _____

Speaking _____